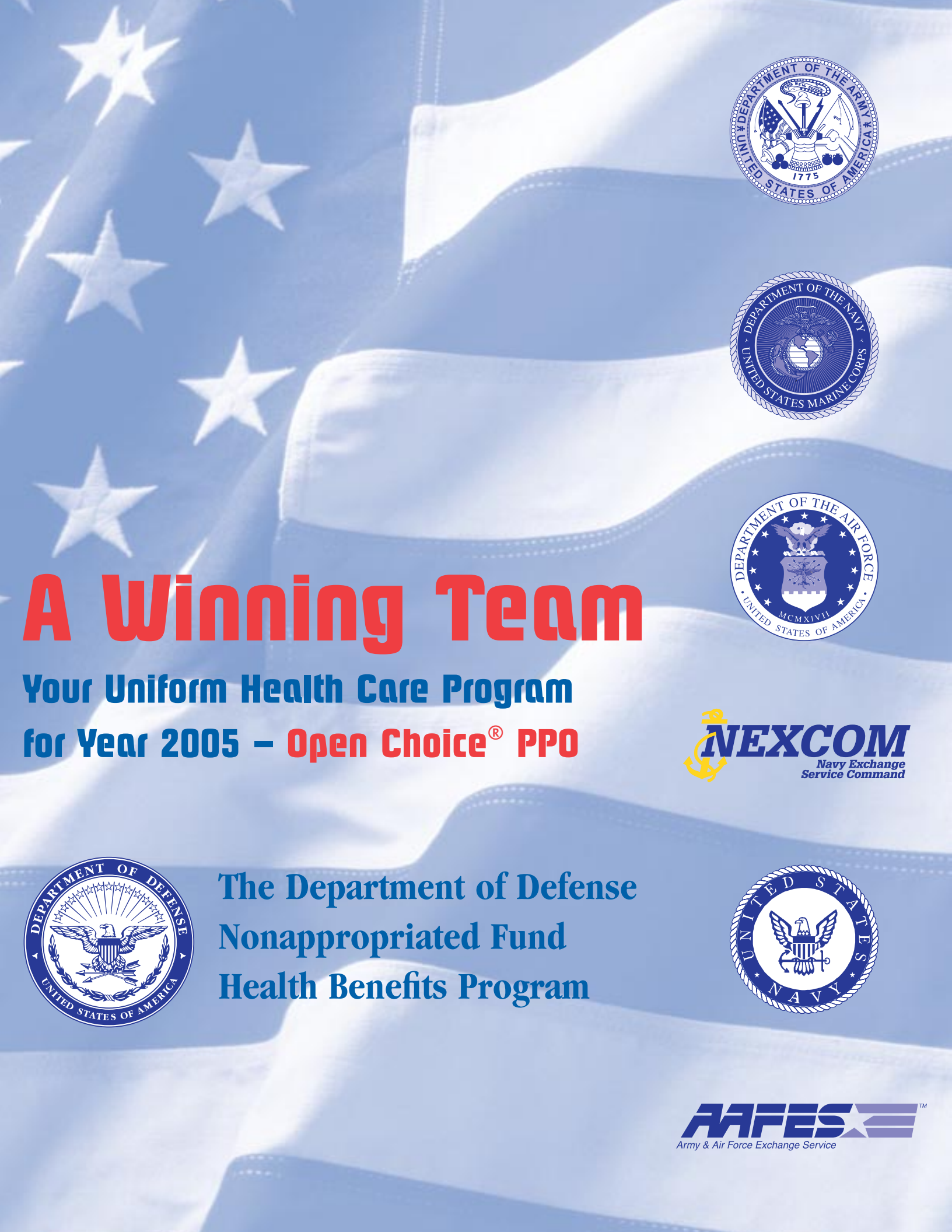


A Winning Team

Your Uniform Health Care Program for Year 2005 – Open Choice® PPO

NEXCOM
Navy Exchange Service Command

The Department of Defense Nonappropriated Fund Health Benefits Program

AAFES™
Army & Air Force Exchange Service

Welcome to Open Choice – for Quality, Affordable Health Care

The Department of Defense is pleased to offer Nonappropriated Fund (NAF) employees and retirees a preferred provider organization plan, called Open Choice, as your medical plan.* You'll find that it offers an excellent way to get the quality health care services you and your family need. It's also easy to use since there are no claim forms to complete, no precertification requirements and no reasonable and customary limits when you use the plan's preferred providers.

You can also save money with Open Choice. Office visits to the doctor are covered for a flat $15 fee, called a copay. When you need a specialist, your office visit copay is $25. Hospital services are covered at 90% after a $200 per confinement fee for each hospital stay. Open Choice also covers preventive care. The following services are covered at 100% with no copay when you receive care from a preferred provider:

- One annual routine physical exam, age 7 and over
- Well-baby care to age seven, including doctor visits and immunizations
- One annual routine gynecological exam, including Pap test and lab fees
- One annual mammogram for women age 35 and over
- One annual prostate screening for men age 40 and over

Understanding the Plan Basics

For some of you, Open Choice is a new way to think about health care. Once you understand it, you're going to enjoy its ease and simplicity. To start you off on the right foot, here are the two main things you need to know about Open Choice. We call them the plan basics.

Plan Basic #1

Open Choice is a network plan

This means that you get your care from doctors, hospitals and other health care providers who belong to an extensive "network" in your local area and who operate their own independent practices. A comprehensive range of medical specialties and services is available so you and your family can get the care you need within the network. Together, network providers deliver health care services at special negotiated rates. As a result, you pay less for your care. All doctors and hospitals are screened before they are admitted to the network and monitored on an ongoing basis once they are in the network. Credentials and licenses are checked to make sure they are valid and current. All providers must be committed to quality, patient-focused care. You will visit network providers in their own private offices.

Plan Basic #2

You choose from two levels of benefits

A very important part of the plan is this: Open Choice gives you two benefit levels to choose from. One is called "preferred care" and the other is called "non-preferred care." The choice is yours each time you need care. Here is the difference:

- *Preferred care.* This is the higher level of benefits. You get preferred benefits when you use network providers.
- *Non-preferred care.* This is the lower level of benefits. You get non-preferred benefits when you use non-network providers.

You will want to get preferred benefits each time you need care. To do this, just follow the steps outlined in this brochure. They will keep you on the winning side.

** Open Choice is administered by Aetna Life Insurance Company and is offered to DoD employees who have access to Aetna's Open Choice PPO network.*

Follow These Steps and Get the Preferred Level of Benefits Each Time You Need Care:

Step 1

Locate Open Choice Providers

The Open Choice network of medical providers is large and comprehensive. To find out which doctors are in the network, you can access Aetna's online provider directory called DocFind®. Log onto **www.aetna.com** and select DocFind from the menu. Then follow the prompts to locate network providers in your area. DocFind is updated three times a week, so it includes the most recent listing of participating network providers. See page 6 for more information about using DocFind.

Step 2

Use network providers each time you need medical care

Each time you need to see a doctor or other health care provider, check DocFind® first for a listing of participating providers. You can do a search to locate participating internists, family practitioners, gynecologists and pediatricians. You can also locate specialists and other health care providers. As long as you use network providers, your care will be covered at the preferred level of benefits.

Step 3

Use your ID card

After you enroll, you will receive two Aetna ID card with the names of all covered family members and the Member Services toll-free number on it. Keep your card handy and show it at the doctor's office to let them know that you are enrolled in Open Choice. Also show it at participating pharmacies in the United States so you get preferred rates for prescription drugs (see page 4 for details). Pharmacy copays are listed on the back of your ID card. *If you don't use participating pharmacies, you won't have any coverage for prescriptions.*

Step 4

Get the help you need in case of an emergency

If you have a medical emergency, go to the nearest hospital immediately and get the care you need. Then, call Member Services. Your benefits will be paid at 100% after a $150 copay as long as it is a true emergency. If you are admitted to the hospital, you will not be required to pay the $150. If you use a hospital emergency room and it's not a true emergency, you must pay 50% of the cost.

A true emergency is a severe illness or accident that could lead to a serious risk to your health or to death if not treated immediately. Examples include bleeding that will not stop, compound bone fractures, loss of consciousness, stroke and severe chest pains.

Sometimes you need urgent – not emergency – care. A sprain or fever are examples of this situation. You should call your network provider in this case, so your care will be covered at the preferred level.

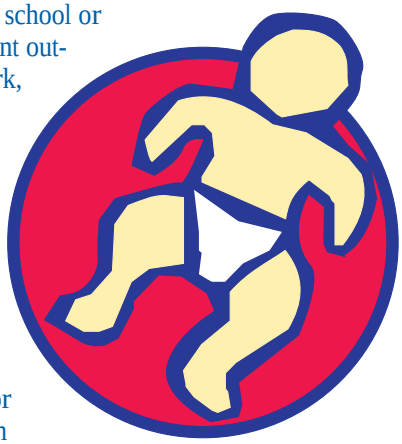
Step 5

Call Member Services before you get care away from home

Aetna maintains Open Choice provider networks throughout the country that you may use. If you are out of your local network area on vacation or business and you need *non-emergency* health care services, call the Member Services toll-free telephone number. Ask the Aetna representative if you are in or near a network area. If so, you may use network providers and receive the preferred level of benefits. If you use non-network providers, your care will be covered at the non-preferred level of benefits. If you are traveling overseas, your covered expenses will be paid at the preferred level. In this case, you will need to submit a claim form.

Step 6

Make sure your children who live away from home use network providers when available



If your child is away at school or lives with another parent outside your home network, you should call Member Services and ask if there is an Open Choice network at that location. If so, log onto DocFind to locate participating providers in that area. If your child's school or home is not in an Open Choice network, ask Member Services if there is one nearby. If your child is willing to travel to see network providers, benefits will be paid at the preferred level.

If a network is not available, your child's benefits will be paid at the Traditional Choice® indemnity plan level of benefits. Traditional Choice is being offered to those employees who live in an area where Open Choice is not available.

Traditional Choice allows you to select any licensed physician you wish when you need care. Once an annual deductible is met, the plan typically pays 80% of the expense, based on reasonable and customary charges, and you pay the balance. To be reimbursed for covered expenses, you must first submit a claim form to Aetna. Contact your supporting Human Resources Office and inform them of any dependent that fits this category. The child's eligibility must be documented as Traditional Choice in order to receive this level of benefits.

Step 7

Learn the facts about non-preferred benefits

Whenever a non-network doctor provides your care, you get the non-preferred level of benefits. *It's very important to know the difference between the two levels of benefits.* Here's how the plan works for non-network care:

- You must meet a deductible before the plan begins to pay benefits.
- You pay the provider, then submit a claim form to Aetna for reimbursement.
- The plan pays 70% of the reasonable and customary charge for covered services. If the doctor charges more than the reasonable and customary charge, you must also pay the difference. (The reasonable and customary amount is the prevailing rate for medical services in your community.)
- Coverage is *not* available for preventive care, including physical exams, OB/GYN exams, well-baby care, mammograms, and routine eye and hearing exams.
- If your doctor wants to admit you to the hospital, you must call Aetna Member Services for precertification and approval. Failure to precertify a hospital admission when required will result in a $500 penalty.

Step 8

Call Aetna Member Services

Here's a great plan feature, one you can use often. It's Aetna Member Services, a toll-free information service. Call Member Services at 1-800-367-6276 for answers to many kinds of questions – *confidentially.* You will speak to an Aetna representative and anything you tell the representative is kept completely private.

Here are just a few of the many reasons you will want to call Member Services:

- For information about network doctors and hospitals, including the doctor's credentials and whether he or she is accepting new patients
- For answers to general health questions
- For information about benefits under your plan
- To precertify hospital care, if required
- To find out if there is an Open Choice network where your child lives with another parent or is away at school
- To check the status of a claim

You can call Member Services from 8 a.m. to 6 p.m. Monday through Friday, Central time. You may also call after hours and use Aetna's Voice Advantage® service to obtain certain information.

Prescription Drug Benefits

Your prescription drugs will be covered under Aetna's Three-Tier Pharmacy Program. The program features three copay levels:

- The lowest copay level is $10 for a 30-day supply of generic drugs included in Aetna's formulary.
- The middle copay level is $25 for a 30-day supply of brand-name drugs included in Aetna's formulary.
- The highest copay level is $35 for a 30-day supply of drugs that are not included in Aetna's formulary.

How do you know which copay goes with which drug? After you enroll, you will receive Aetna's Formulary Guide, which lists over 900 drugs and the copay level for each one. All drugs in the Aetna formulary have been approved by the Food and Drug Administration as safe and effective. For additional information about Aetna's formulary, go to **www.aetna.com** or call Member Services.

Using the plan

The three-tier copay structure applies to prescriptions filled at participating retail pharmacies located in the United States as well as to prescriptions filled through the Aetna Rx Home Delivery℠ Program. Here's how these programs work:

- ***The Participating Pharmacy Program for up to a 30-day supply of prescription medication***

  Take your prescription and your Aetna medical plan ID card to any participating pharmacy located in the United States. Your copay is payment in full at the time of purchase. There are no claim forms to complete, participating pharmacists file claim forms electronically for you. If they have any questions, they can call Aetna's toll-free 24-hour provider helpline for answers.

  To find a participating pharmacy nearby, visit DocFind at **www.aetna.com**, and follow the search instructions for pharmacies. Or, call Member Services for a listing or participating pharmacies. The network includes over 50,000 chain and local independent pharmacies. That's 82% of all pharmacies.

  Please note: There is no coverage for prescription drugs purchased at non-participating pharmacies in the United States.

- ***Aetna Rx Home Delivery℠ Program for a 31- to 90-day supply of prescription medication***

  Use Aetna's mail-order program for medications you need on a regular, long-term basis. You may order up to a 90-day supply *for a single copay* and have the prescription sent to your home address. If you have questions about your prescription, program pharmacists are available to answer them. Mail-order pharmacies use the same quality checks on prescriptions as participating retail pharmacies. For more information, call the Member Services number on your ID card, which you will receive after you enroll.

  The mail order program also features three copay levels for a 31- to 90-day supply of prescription drugs as follows:
  - $20 for generic drugs included in Aetna's formulary
  - $40 for brand-name drugs included in Aetna's formulary
  - $60 for drugs that are not included in Aetna's formulary.

It's always a good idea to tell your pharmacist about your other medications when having a new prescription filled. Pharmacists can tell you if there is a risk of harmful drug interactions. Pharmacists in both programs have access to Aetna's claim processing system and can review other covered drugs filled through an Aetna prescription plan to identify interaction issues.

What are you willing to pay?

In some cases, treatment requires a brand-name drug. In other cases, the choice is yours. Ask your doctor if the medication he or she prescribes is a covered brand-name or generic drug and whether it's included in Aetna's formulary. You may be able to have your prescription filled with a lower-cost formulary generic drug instead of paying much more for a brand-name drug.

Generic drugs must meet the same FDA standards for safety and effectiveness as their brand-name counterparts. Generic drugs must:

- Contain the same active ingredients in the same amount as the brand-name equivalent
- Carry the same label information as the brand-name equivalent

Vision One® Discount Program

With Open Choice, prescription eyewear is covered at 100%, up to $75 a year for each covered family member. In addition, you are eligible to use the Vision One Discount Program when your Open Choice coverage takes effect. Vision One offers discounts of 20-70% on eyeglasses, contact lenses, nonprescription sunglasses, contact lens solutions and accessories. To receive discounts, visit any Vision One location and show your medical plan ID card. The discount will be applied at the time of purchase. For more information or to find the nearest Vision One location, call 1-800-793-8616 weekdays from 9 a.m. to 9 p.m. or on Saturdays from 9 a.m. to 5 p.m. Eastern time.

Alternative Health Care Programs

If you and your covered dependents wish to receive chiropractic care (beyond your medical plan coverage), acupuncture, massage therapy or nutrition counseling, the Natural Alternatives™ program can help you save money. This discount program is available to you automatically once you enroll in Open Choice. To use the program, you simply visit one of the participating providers, then pay the special discounted fee at the provider's office when you receive the service.

You also receive savings on vitamins, herbal supplements, and health-related books and magazines that you may order through the Vitamin Advantage™ Program.

For further information about these programs and for the names of participating providers in your area, call Member Services or visit Aetna's website at **www.aetna.com**.

The National Medical Excellence® Program

For extremely complex medical procedures, Open Choice includes Aetna's National Medical Excellence Program. This voluntary program is available if your network provider decides that you need to have a highly specialized medical procedure performed, such as an organ transplant. Coverage includes surgery for organ and tissue transplants such as heart, lung, liver, bone marrow, kidney or pancreas. Certain organ transplant combinations are also covered.

The procedure will be performed at a designated Institutes of Excellence® hospital. These hospitals have national reputations for their skill at certain types of organ transplants and complex medical care. Surgical teams in these hospitals perform many of these specialized procedures and have a proven track record of success.

Your network provider and an Aetna case manager will coordinate your care. If the hospital is more than 100 miles from your home, you will also receive a travel and lodging benefit for you and one companion. Please refer to your Summary Plan Description for details.

Healthy Outlook Disease Management Programs

Living with chronic health problems can be difficult. But you don't have to fight these conditions alone. Two disease management programs are available as part of your benefit plan. Both programs are voluntary, confidential and offered at no additional cost to you:

- Caring for Chronic Heart Failure
- Caring for Diabetes

Both programs offer screenings to determine the severity of your condition, a subscription to *Living Well* magazine, access to a disease management question- and answer-phone line. In many cases, you'll also receive disease specific counseling and educational counseling to help you better manage your care.

By reviewing claim history, Aetna identifies potential candidates for each program. An Aetna Nurse Consultant will contact you and invite you to participate. Your decision to participate is completely up to you. Please remember, your medical information is confidential and is not shared with your employer.

By learning more about your condition, you can help to reduce symptoms and prevent it from becoming more severe.

Dental Plan

If you enroll in Open Choice, you may also enroll in the dental plan. The dental plan offers comprehensive coverage and gives you the freedom to use any dentist you wish. However, when you receive dental care from a dentist who belongs to Aetna's dental provider network, you'll pay less for your care. This is called a *Passive Dental Preferred Provider Organization* (PPO).

How does it work? Network dentists have negotiated their fees with Aetna. They generally charge less than non-network dentists, so your share of the smaller amount is less. Network dental providers also file claims for you. When you receive care from a dentist who does *not* participate in Aetna's dental network, your benefits are based on the reasonable and customary charge for that service in your geographic area – which is higher than the negotiated fee. As a result, your share of the cost may be higher.
In addition, you may need to file your own claims with Aetna to be reimbursed for your covered expenses. To see if your dentist participates in Aetna's network, click on DocFind® at **www.aetna.com**.
If you would like a directory of participating dentists, call Member Services at 1-800-367-6276.

Using a network dentist is voluntary. Either way, the same services are covered. To encourage good dental health, the plan pays 100% for preventive care services, with no deductible. For more advanced care, the plan pays a share of the expense, depending on the service you receive. Please refer to the enclosed Dental Plan Summary of Benefits for information about how dental services are covered under the plan.

Benefits information at your fingertips

Have you ever needed a quick answer to a benefits question? With Aetna Navigator, information is available in seconds. Find out about who's covered for what and the status of a claim. Click to view your Explanation of Benefits Statement (EOB). Look up your Member Services telephone number and address. Research health information at home and at your convenience. You even have access to a medical dictionary.

Aetna Navigator also features a hospital comparison tool that allows you to learn how hospitals in your area rank on measures that are important to your care (such as the frequency a certain procedure is performed).

Speedy transactions

Aetna Navigator is also interactive. Use it to request information, send messages to Member Services, provide additional information needed for a claim or request replacement medical ID cards. And, if you need any standard Aetna forms, print them out from Aetna Navigator.

DocFind®

One of Aetna Navigator's premium services is DocFind, Aetna's online provider directory where you can get a wealth of information about participating hospitals, physicians and pharmacies – including maps and directions, a physician's education and languages he or she speaks.

Aetna InteliHealth®

Aetna Navigator is also your gateway to InteliHealth, an award-winning site that provides in-depth health information plus wellness and fitness tips.

New services and features are constantly being developed that will help you manage your health. Check out Aetna Navigator today!

Enrollment Instructions

During the Annual Plan Selection Period

If you are currently enrolled in the plan, your coverage will automatically continue. There is no need to re-enroll at this time. However, if you wish to make a change for 2005, please see your supporting Human Resources Office for detailed enrollment instructions.

New Employees

Newly hired employees must enroll in order to have coverage under the Department of Defense NAF Health Benefits Program. Otherwise, you will need to wait for the next full Open Enrollment Season to enroll in the plan, unless you have a valid Family Status Change (such as a marriage, divorce, birth or adoption). To enroll, please follow the enrollment instructions provided by your supporting Human Resources Office.

Coverage for Newborns

Important! During the first 31 days, your newborn is automatically covered under your medical plan. However, you must enroll your newborn child within 31 days of birth for coverage to continue. Please contact your supporting Human Resources Office for enrollment instructions.

DoD OC 0-4-0284 (9/04)